younger from common diseases and to suffer illnesses in which environment and lifestyle play an important part. Men are more likely than women to have unhealthy lifestyles, to drink too much alcohol, to smoke tobacco, and to eat a less healthy diet.[6] Risk taking and aggression, commonly exacerbated by alcohol, are more prevalent among men, as reflected by the higher accident fatality rates. Men in England and Wales have an average life expectancy that is six years shorter than women's, a 3·5 times higher risk of death from coronary heart disease under 65, a suicide rate double that of women, and a greater risk of contracting HIV and AIDS. The recent report on variations in health[7] showed not only that there is a gap in mortality between men and women but that it is increasing. This has also been noted in the United States.[8]

It is not just the impact of lifestyles and biology but society's expectations of men that need to be addressed. Such expectations have created an environment in which men are less able than women to recognise physical and emotional distress and to seek help. Available data show that for most illnesses men are less likely than women to consult their general practitioners,[9] yet their hospital admission rates for diseases such as coronary heart disease and stroke are higher.

The common assertion that women consistently report higher levels of ill health than men is now being questioned. MacIntyre and colleagues have found that the direction and magnitude of sex differences in health vary according to the particular symptom or condition in question and the patient's phase of life.[10] They suggest that sex differences have become oversimplified and should be re-examined periodically to monitor the impact of changes in sex roles on people's experiences of health and illness.

Differences in health status between groups of men are also of concern. The inverse social gradient for mortality is unlikely to be due solely to social class differences in individual lifestyles. Research shows that men of lower social status suffer more financial problems, more stressful life events, less adequate social support, and more feelings of disempowerment within the workplace. In Britain, Asian men have higher rates of heart disease than do their white compatriots,[11] and, as noted by Professor Michael Chan at the Medical Group conference on men's health in London last July, Afro-Caribbean men are more likely to suffer from severe mental illness and to be admitted to secure wards. Professor Chan, director of the NHS ethnic health units, suggested that improving the health of men from ethnic minorities will depend on reducing stress generated by unemployment, poor housing, and other forms of racism.

There is little evidence for effective interventions to remedy the inequalities in health faced by men, but the experience of the HIV/AIDS programmes suggests that men need to be targeted, particularly at places where they meet together.[12] Even if equitable health status for all men will be achieved only by redressing social inequalities, more could certainly be done to increase men's access to health care and to promote health, especially in the workplace.

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Contestability: a middle path for health care

Combines competition with planning

Quietly in the night, competition in British health care has slipped away, its passing unremarked and little noticed by those who brought it into this world. The death sentence was first signalled by William Waldegrave when he was secretary of state for health. As Mr Waldegrave commented at the time, the NHS market "isn't a market in the real sense . . . it's competition in the sense that there will be comparative information available."[1] The change of direction was confirmed by Virginia Bottomley. In her valedictory speech in 1995 Mrs Bottomley extolled the virtues of planning and collaboration; the word "competition" scarcely crossing her lips.[2] Her successor, Stephen Dorrell, has echoed this line, most notably in a personal letter to the chairs of health authorities and trusts. In his letter Mr Dorrell referred to the achievements of the NHS management reform, and at no point did he mention markets and the benefits that would arise from competition in future. Indeed, when was the last time any health minister urged those in the NHS to leave behind the legacy of planning and grasp the competitive opportunities available to them?

The decoupling of markets and health care is not a uniquely British phenomenon, as developments in Sweden and to a lesser extent the Netherlands indicate. After a decade in which competition was seen as the solution to the problem of inefficient health service provision, new ideas are under debate. It seems as if the competition vogue may have had its day, although in the eddying currents of political debate it is not always clear when the tide has finally turned.

Why has the attempt to bring markets into health care been a policy failure? In the British context there are several reasons. To begin with, the scope for competition in many parts of the NHS is limited by the existence of monopoly providers. Furthermore, even where there is a choice of providers, it has been difficult to control the effects of market forces. The result has been harmful instability, particularly in London and other cities where major changes in hospital provision have emerged onto the agenda. In recognition of the limits of competition, managers and doctors have moved increasingly to establish collaborative arrangements in which purchasers and providers work together on a long term basis. Not only is this a pragmatic response to weaknesses in the original policy design, but also it has been justified by reference to best practices in industry. Successful companies, it is argued, work in partnership with their suppliers and seek

to create "win-win" relationships. By extension, critics of competition maintain that the NHS should do the same. These developments have been reinforced by concerns about the increase in management costs associated with the introduction of competition.

Estimates suggest that the NHS reforms may have resulted in up to £1bn extra being spent on administration, although changes in definitions make it difficult to be precise. This is because of the need to employ staff to negotiate and monitor contracts and to deal with the large volumes of paperwork involved in the contracting system. Ministers have responded to these concerns by streamlining the organisation of the NHS and introducing tight controls over management costs. They have also encouraged the use of long term contracts in order to reduce the transaction costs of the new arrangements.

Out of the ashes of competition has arisen a different policy agenda. This owes less to a belief in market forces than a desire to use the NHS reforms to achieve other objectives. The current agenda centres on policies to improve the health of the population, give greater priority to primary care, raise standards through the patient's charter, and ensure that medical decisions are evidence based. These policies hinge on effective planning and coordination in the NHS and all have been made more salient by the separation of purchaser and provider roles on which the reforms are based.

In particular, the existence of health authorities able to take an independent view of the population's health needs without being beholden to particular providers has changed the way in which decisions are made. To this extent the organisational changes introduced in 1991 have served to refocus attention on those whom the NHS exists to serve, even though the effects were neither anticipated nor intended when the reforms were designed. Like a potter moulding clay, only in the process of creation has the shape of the product become apparent. The effect of this policy shift has been to open up common ground between Labour and the Conservatives, notwithstanding the differences that remain.

Yet before the obituary of competition is written, the consequences of a return to planning need to be thought through. The NHS was reformed precisely because the old command and control system had failed to deliver acceptable improvements in efficiency and quality, and the limitations of planning must also be acknowledged. While competition as a reforming strategy may have had its day, there are nevertheless elements of this strategy which are worth preserving. Not least, the stimulus to improve performance which arises from the threat that contracts may be moved to an alternative provider should not be lost. The middle way between planning and competition is a path called contestability. This recognises that health care requires cooperation between purchasers and providers and the capacity to plan developments on a long term basis. At the same time, it is based on the premise that performance may stagnate unless there are sufficient incentives to bring about continuous improvements. Some of these incentives may be achieved through management action or professional pressure, and some may derive from political imperatives.

In addition, there is the stimulus to improve performance which exists when providers know that purchasers have alternative options. This continues to be part of the psychology of NHS decision making, even though ministers seem reluctant to use the language of markets. It is, however, a quite different approach than competitive tendering for clinical services, which would expose providers to the rigours of the market on a regular basis.

The essence of contestability is that planning and competition should be used together, with contracts moving only when other means of improving performance have failed. Put another way, in a contestable health service it is the possibility that contracts may move that creates an incentive within the system, rather than the actual movement of contracts. Of course for this to be a real incentive then contracts must shift from time to time, but this is only one element in the process and not necessarily the most important. As politicians prepare their plans for the future it is this path that needs to be explored.

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Evidence based medicine: what it is and what it isn't

It's about integrating individual clinical expertise and the best external evidence

Evidence based medicine, whose philosophical origins extend back to mid-19th century Paris and earlier, remains a hot topic for clinicians, public health practitioners, purchasers, planners, and the public. There are now frequent workshops in how to practice and teach it (one sponsored by the *BMJ* will be held in London on 24 April); undergraduate[1] and postgraduate[2] training programmes are incorporating it[3] (or pondering how to do so); British centres for evidence based practice have been established or planned in adult medicine, child health, surgery, pathology, pharmacotherapy, nursing, general practice, and dentistry; the Cochrane Collaboration and Britain's Centre for Review and Dissemination in York are providing systematic reviews of the effects of health care; new evidence based practice journals are being launched; and it has become a common topic in the lay media. But enthusiasm has been mixed with some negative reaction.[4-6] Criticism has ranged from evidence based medicine being old hat to it being a dangerous innovation, perpetrated by the arrogant to serve cost cutters and suppress clinical freedom. As evidence based medicine continues to evolve and adapt, now is a useful time to refine the discussion of what it is and what it is not.

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the